Carolinas HealthCare System LiveWell Health Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 - 12/31/2017

Coverage for: Plan Participant Plan Type: Consumer Directed Health Plan

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.medcost.com or by calling 1-800-795-1023.

Important Questions	Answers			Why this Matters:
	CHS	**In-Network**	**Non- Network**	
What is the overall deductible?	$1,850 / person $3,700 / family	$2,600 / person $5,200 / family	$4,000 / person $8,000 / family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
	Does not apply to most preventive care.			
Are there other deductibles for specific services?	No			You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes $5,600 / person $11,200 / family	Yes $6,450 / person $12,900 / family	Yes $11,000/ person $22,000 / family	The **out–of–pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balanced-billed charges, health care this plan doesn't cover, and penalties.			Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No			The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.medcost.com or call 1-800-795-1023 for a list of participating providers.			If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **provider**.
Do I need a referral to see a specialist?	No			You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes			Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-795-1023 or visit us at **www.medcost.com**.
If you aren't clear about any of the bolded terms used in this form, see the Glossary.
You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-795-1023 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an			Limitations & Exceptions
		CHS	In-Network Provider	Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	25% co-insurance	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Specialist visit	25% co-insurance	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Other practitioner office visit - Chiropractor	25% co-insurance*	25% co-insurance*	50% co-insurance**	Maximum $1,500 / calendar year. *Co-insurance applies after CHS deductible. **Co-insurance applies after Non-Network deductible.
	Preventive care/screening/immunization	No charge	No charge	No coverage*	Deductible waived. *Child to age 2 - Non-Network 50% co-insurance after deductible.
If you have a test	Diagnostic test (x-ray, blood work)	25% co-insurance*	25% co-insurance*	50% co-insurance**	*Co-insurance applies after CHS deductible. **Co-insurance applies after Non-Network deductible.
	Imaging (CT/PET scans, MRIs)	25% co-insurance*	25% co-insurance*	50% co-insurance**	*Co-insurance applies after CHS deductible. **Co-insurance applies after Non-Network deductible.

Common Medical Event	Services You May Need	Your cost if you use an CHS Retail Pharmacy	Your cost if you use an Other Retail Pharmacy	Your cost if you use an Mail Order (CarolinaCARE) (30 day or 90 day supply)	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.carolinacarerx.org or (866) 697-6800.	CHS Preventive drugs	$4 co-pay	$15 co-pay	$4 co-pay, 30 day supply $12 co-pay, 90 day supply	*Co-insurance or co-pay applies after CHS deductible shared with medical plan is met. Co-pay covers 30 day supply when using a retail pharmacy, or 30 days or 90 days when using mail order through CarolinaCARE. FDA approved contraceptives, smoking cessation products, and certain over-the-counter preventive medications (with prescription) are covered at 100%. Refer to ACA Preventive List available from pharmacy administrator (www.carolinacarerx.org or 866-697-6800). **Note for maintenance medications**: There is a one fill at retail maximum for ACA Preventive and Generic Preventive maintenance drugs. When requesting the second fill, the drug must be transferred to CarolinaCARE or the drug will not be covered. All other maintenance drugs can be filled at retail until the deductible is met. Once met, the one fill maximum is applied and must be transferred to CarolinaCARE or the drug will not be covered. Drugs filled at retail after the one fill maximum will not apply to deductibles or annual out-of-pocket limits.
	Generic brand drugs	$10 co-pay*	$15 co-pay*	$10 co-pay*, 30 day supply $25 co-pay*, 90 day supply	
	Preferred brand drugs	$35 co-pay*	30% co-insurance (minimum $35, maximum $100)*	$35 co-pay*, 30 day supply $85 co-pay*, 90 day supply	
	Non-preferred brand drugs	40% co-insurance (minimum $50, maximum $150)*	50% co-insurance (minimum $60, maximum $250)*	40% co-insurance (minimum $50, maximum $150)*, 30 day supply 40% co-insurance (minimum $125, maximum $375)*, 90 day supply	
	Brand name drugs with generic equivalent	No coverage without prior authorization. If the prior authorization is approved, coverage will be the same as Non-preferred brand drugs.			
	Specialty drugs	20% co-insurance (maximum $125)* Specialty drugs required at CarolinaCARE. Some exceptions may apply to limited distribution drugs and certain infertility drugs.			

Common Medical Event	Services You May Need	Your cost if you use a CHS	Your cost if you use a In-Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance	40% co-insurance	50% co-insurance	Co-insurance applies after deductible.
	Physician/surgeon fees	25% co-insurance	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If you need immediate medical attention	Emergency room services	25% coinsurance	25% coinsurance	25% coinsurance	Co-insurance applies after CHS deductible.
	Emergency medical transportation	25% co-insurance	25% co-insurance	25% co-insurance	Co-insurance applies after CHS deductible.
	Urgent care	25% co-insurance*	25% co-insurance*	50% co-insurance**	*Co-insurance applies after CHS deductible. **Co-insurance applies after Non-Network deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance	40% co-insurance	50% co-insurance	Co-insurance applies after deductible. Precertification required.
	Physician/surgeon fee	25% co-insurance	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.

Common Medical Event	Services You May Need	Your cost if you use a CHS	Your cost if you use a CBHA In-Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient Services - Facility - Physician	 30% co-insurance 25% co-insurance	 40% co-insurance 30% co-insurance	 50% co-insurance 50% co-insurance	Co-insurance applies after deductible.
	Mental/Behavioral health inpatient services	30% co-insurance	40% co-insurance	50% co-insurance	Co-insurance applies after deductible. Precertification required.
	Substance use disorder outpatient services - Facility - Physician	 30% co-insurance 25% co-insurance	 40% co-insurance 30% co-insurance	 50% co-insurance 50% co-insurance	Co-insurance applies after deductible.
	Substance use disorder inpatient services	30% co-insurance	40% co-insurance	50% co-insurance	Co-insurance applies after deductible. Precertification required.

Common Medical Event	Services You May Need	Your cost if you use an CHS	Your cost if you use an In-Network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	25% co-insurance*	25% co-insurance*	50% co-insurance**	*Co-insurance applies after CHS deductible. **Co-insurance applies after Non-Network deductible.
	Delivery and all inpatient services	30% co-insurance	40% co-insurance	50% co-insurance	Co-insurance applies after deductible. Includes birthing centers.
If you need help recovering or have other special health needs	Home health care	25% co-insurance*	25% co-insurance*	50% co-insurance**	*Co-insurance applies after CHS deductible. **Co-insurance applies after Non-Network deductible.
	Rehabilitation services - Cardiac rehabilitation - Pulmonary and respiratory therapy	25% co-insurance* 25% co-insurance*	30% co-insurance 25% co-insurance*	50% co-insurance** 50% co-insurance**	Includes cardiac, pulmonary, and respiratory therapy. Cardiac therapy maximum 90 visits / calendar year. Pulmonary and respiratory maximum 50 visits / calendar year for each type of therapy. *Co-insurance applies after CHS deductible. **Co-insurance applies after Non-Network deductible.
	Habilitation services	25% co-insurance*	25% co-insurance*	50% co-insurance**	Includes physical therapy, speech therapy, and occupational therapy. Physical therapy is limited to 30 visits / calendar year. Speech and occupational therapy are limited to 20 visits each / calendar year. *Co-insurance applies after CHS deductible. **Co-insurance applies after Non-Network deductible.
	Skilled nursing care	25% co-insurance	25% co-insurance	25% co-insurance	Co-insurance applies after CHS deductible. Maximum 100 days / lifetime.
	Durable medical equipment	25% co-insurance*	25% co-insurance*	50% co-insurance**	*Co-insurance applies after CHS deductible. **Co-insurance applies after Non-Network deductible.
	Hospice service	25% co-insurance	30% co-insurance	50% co-insurance	Co-insurance applies after deductible.
If your child needs dental or eye care	Eye exam	Not applicable	Not applicable	Not applicable	No coverage available
	Glasses	Not applicable	Not applicable	Not applicable	No coverage available
	Dental check-up	Not applicable	Not applicable	Not applicable	No coverage available

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Hearing aids
- Infertility treatment
- Private-duty nursing
- Weight loss programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at Group's Phone #704-631-0263. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the claims administrator, MBS; P. O. Box 25987; Winston-Salem, NC; 27114-5987; or http://www.medcost.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally a consumer assistance program can help you file your appeal. Contact North Carolina Department of Insurance; Health Insurance Smart NC; 430 N. Salisbury Street; Raleigh, NC 27603 or 1-877-885-0231 or http://www.ncdoi.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-795-1023

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-795-1023

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-795-1023

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-795-1023

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,190
- **Patient pays** $3,350

Sample care costs:

Hospital charges (mother)*	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)*	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions**	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,850
Co-pays	$50
Co-insurance	$1,450
Limits or exclusions	$0
Total	**$3,350**

Assumptions:
*Domestic facility
**Generic Tier 2, domestic mail order, filled 2 times

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays** $3,072.50
- **Patient pays** $2,327.50

Sample care costs:

Prescriptions*	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures**	$700
Education***	$300
Laboratory tests****	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,850
Co-pays	$340
Co-insurance	$137.50
Limits or exclusions	$0
Total	**$2,327.50**

Assumptions:
*Insulin (preferred brand) via mail order, 4 times
**4 PCP visits and 2 specialist visits
***4 visits for diabetic education
**** Independent facility

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

11/1/2016